Maryland Health Care Commission

Thursday, January 17, 2019

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**
2. UPDATE OF ACTIVITIES
3. ACTION: Certificate of Need - Western Maryland Home Health Agency Review
   - Adventist Home Health Services, Inc. (Docket No. 17-R2-2397)
   - Amedisys Maryland, L.L.C. d/b/a Amedisys Home Health (Docket No. 17-R2-2398)
   - Bayada Home Health Care, Inc. (Docket No. 17-R2-2399)
4. PRESENTATION: Increasing Public Awareness of the Healthcare Quality Reports Consumer Website: Strategy and Early Results
5. ACTION: Coverage and Reimbursement for Emergency Medical Services New Care Delivery Models: Reports required under Senate Bill 682
6. PRESENTATION: Legislative Health IT Workgroups Update
7. PRESENTATION: Legislative Process for Calendar Year 2019
8. PRESENTATION: MHCC Strategic Priorities
9. PRESENTATION: State Health Plan Priorities
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11. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

APPROVAL OF MINUTES

(Agenda Item #1)

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

(Agenda Item #2)

MARYLAND HEALTH CARE COMMISSION

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(Agenda Item #3)

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Increasing Public Awareness of the Healthcare Quality Reports Consumer Website: Strategy and Early Results

(Agenda Item #4)

Increasing Public Awareness of the Healthcare Quality Reports Consumer Website: Strategy and Early Results

Courtney Carta, Chief, Hospital Quality Initiatives

January 17, 2019

Presentation Outline

- Overview of consumer website marketing strategies
- Preliminary results of advertising campaign
- Future plans

Public Awareness Campaign

- Develop a message that it simple and direct
  - Help consumers make informed decisions about their care
  - Help patients and families compare and monitor performance
- Audience
  - Consumers (Primary)
    - Patients, family members, seniors/caretakers
  - Healthcare providers
  - Employers
  - Policy Professionals
  - Advocacy Groups

Past Marketing Strategies

- Focus groups
- Press Releases
- Articles and news stories with local news affiliates
- Articles for federal newsletters (e.g., AHRQ, CDC)
- Link included on websites of partnering agencies (e.g., MHA)
- Marketing contract (e.g., radio ads, Facebook ads, banners, rack cards)

Current Marketing Strategies

- Local conferences
  - Networking
  - Promotional materials
- Social media
  - ~20 posts/month
  - Paid advertisements

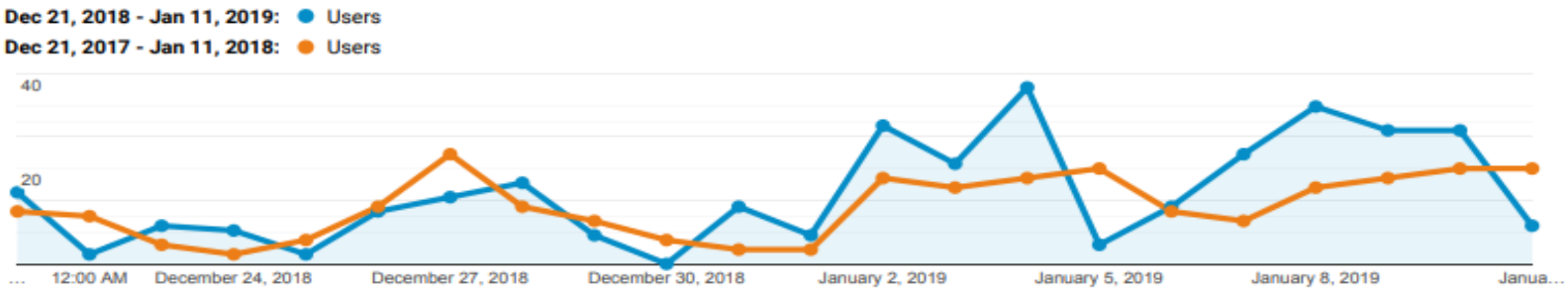
Office of Minority Health and Health Disparities Health Equity Conference (12/6/18)

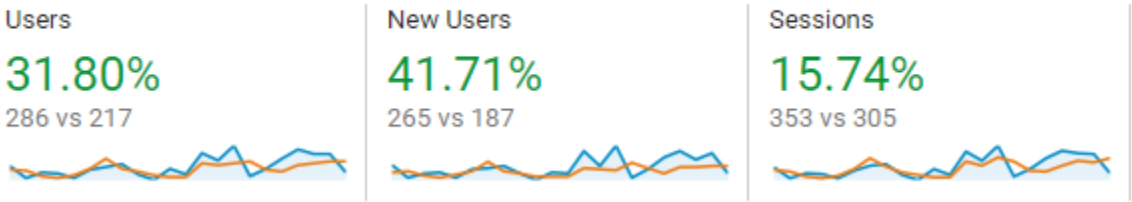
Video Campaign

- Animated "How-to" video with a focus on long term care
  - Consumer website homepage
  - Social media (e.g., YouTube)
- Movie theater advertising
  - On-screen – 49 movie theaters across the state
    - 36 NCM theaters (11 week campaign)
    - 13 Screenvision theaters (discount theaters; 8 week campaign)
  - Lobby monitors – 15 commercials per hour
  - Standees – 1 in each movie theater in a high traffic area
  - Digital banner ads – 3 revolving still images

Preliminary Results

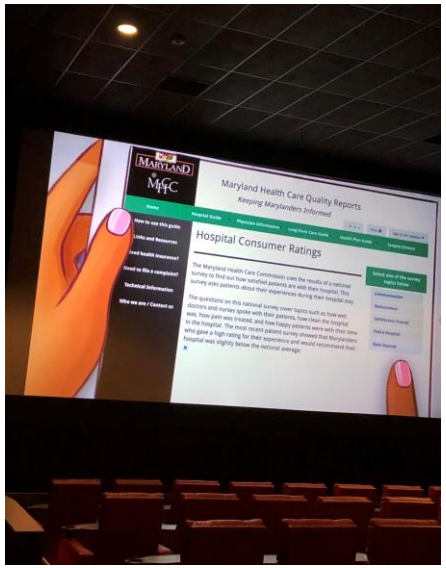
- Campaign is still in progress (12/21/18-2/21/19)
  - 32% user increase from same time period last year
  - 41% increase in **NEW** users
  - 26% click through rate on YouTube

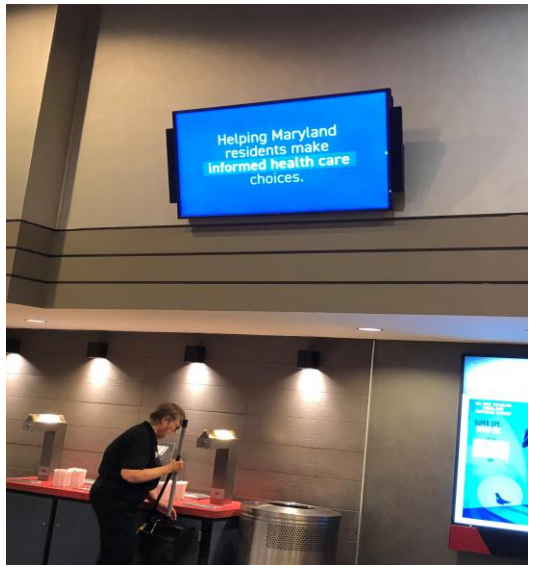




Preliminary Results

- Positive comments from moviegoers include:
  - “Commercial presents an eye catching image – the animation and colors grab attention.”
  - “The message is clear and concise.”
  - “We weren’t aware that this type of service was available. Now we are!”





Future Plans

- Continue current promotional efforts
- Consider more videos with additional topics
  - Potential for additional mediums (e.g., radio, tv)
  - Expand audience targeting
- Continue networking and collaboration
- Focus groups planned for later on in the year

Questions?

MARYLAND HEALTH CARE COMMISSION

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ACTION:

Coverage and Reimbursement for Emergency Medical Services New Care Delivery Models: Reports required under Senate Bill 682

(Agenda Item #5)

Coverage and Reimbursement for three Emergency Medical Services Care Delivery Models

Reports required under Senate Bill 682

Megan Renfrew
Government Relations and Special Projects
January 17, 2019

MHCC | MARYLAND HEALTH CARE COMMISSION

Charge

- Requested by: SB 682
- Tasks:
  - Study reimbursement for the following Services:
    - emergency medical services without transport
    - emergency medical services with transport to an alternative destination
    - mobile integrated health services
  - Develop plan for Medicaid reimbursement
  - Develop process for obtaining Medicare reimbursement
  - Report on findings and recommendations related to private market insurance reimbursement.

MHCC MARYLAND HEALTH CARE COMMISSION

Membership & Process

- MHCC & MIEMSS co-lead
- Membership: Hospitals, Providers, Insurers, MDH/Medicaid, HSCRC, MIEMSS, MHCC, Local EMS
- State steering committee—many meetings
- Work Group- 3 meetings
- EMS Board review- 1/15 (Tuesday)

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3 Models: Treat and Release

- Two types:
  - **Routine:** EMS provides services to a 9-1-1 patient at the scene (ex. diabetic, asthma, overdose). The patient refuses ambulance transport to the hospital emergency department.
    - No reimbursement is available for services and supplies provided by any public or private payer in Maryland.
    - Note that Anthem BCBS now covers routine EMS trips with no transport in states where it sells.
  - **Innovative:** Minor Definitive Care Now in West Baltimore.
    - Normal EMS response
    - EMS determines patient is low acuity
    - Request patient consent to treat on-scene.
    - DR or NP in chase vehicle provides on-scene treatment and referral.
    - Subject to MIEMSS Pilot Protocol
    - Grant funded
    - DR and NP could likely bill, but EMS could not.

3 Models: Alternative Destination

- EMS transports 9-1-1- patients with low acuity conditions to an urgent care clinic or similar care environment instead of the ED.
- Pilots in West Baltimore & Montgomery County
- Grant funded.

3 Models: Mobile Integrated Health

- EMS partners with other health care providers (nurse practitioners, community health workers, social workers, and/or physicians)
- Home visits to assess, treat and refer certain 9-1-1 patients to needed services in the community.
- Focus on patients who are
  - frequent 9-1-1 callers,
  - frequent users of EMS transport, and/or
  - patients identified by hospitals as being at high risk for hospital readmission.
- 7 pilots in Maryland, grant funded, subject to MIEMSS protocols

Current Funding

- Public Safety EMS budgets come from county/local funds + billing insurance + any additional funds (grants, fundraising, etc.).
- Currently EMS reimbursed for transportation to ED, as transportation service.
  - Medicaid pays flat $100/trip.
  - Medicare and private payers pay based on complexity of the transport + mileage

Recommendations: Vision Statements / Guidelines for Recommendations

- The three EMS models of care need long-term sustainable funding solutions to continue and to grow.
- Reimbursement for the three EMS care models must be financially and practically viable for all system participants, including payers.
- Reimbursement for the three EMS care models should include all private and public payers to avoid cost-shifting between payer types and to ensure equitable treatment of consumers, regardless of insurance source.
- EMS reimbursement changes must dovetail with the requirements of the Total Cost of Care (TCOC) Model.

Recommendations: Medicaid

- MIEMSS and Medicaid should develop reasonable cost projections for all three models of EMS care, through increased and enhanced collaboration with EMS jurisdictions, Managed Care Organizations (MCOs), and MIEMSS.
- Medicaid should include studying the three models of EMS care as it considers developing total cost of care savings initiatives.

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Recommendations: Medicare & HSCRC

- The Health Services Cost Review Commission (HSCRC) should expand grant opportunities for the three EMS care delivery models to allow EMS programs to apply for grant funding, in partnership with local hospitals, to fund EMS programs that have the potential to contribute to Medicare savings and reduce unnecessary hospital utilization.
- HSCRC and the State Innovation Group should consider these models of EMS care in the process of developing proposals for the Centers for Medicare & Medicaid Services (CMS) for new tracks for the Care Redesign program for Medicare funding under the TCOC Model.
- HSCRC should periodically review opportunities to incorporate the of three EMS care delivery models as potential New Model Programs, which allows for programs where EMS providers may assume financial risk for Medicare beneficiary costs without a hospital partner.
- Through the TCOC Model, HSCRC should encourage participation by hospitals and other health care providers in the three models of EMS care.
- HSCRC should continue to identify and consider EMS care delivery financing models that occur outside of Maryland for possible proposals to the Center for Medicare and Medicaid Innovation (CMMI) at CMS for approval under the TCOC Model, including any future EMS-focused models developed by CMMI.

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Recommendations: MIEMSS and MHCC

- MIEMSS should develop an Alternative Destination designation process whereby alternative destinations can be approved to receive and treat EMS ambulance transported, low acuity 9-1-1 patients.
- MIEMSS should compile and analyze data from current pilot EMS new care delivery model programs, including evaluation data comparable among the programs, to provide additional support for the business case for public and private payer support for these programs.
- MIEMSS should continue to evaluate the percentage of treat and release visits compared to all EMS services.
- MIEMSS should continue to work with local EMS programs to consider and address any data issues that may impact payers.
- Working with EMS and payers, MIEMSS and MHCC should create a forum for discussion of changes in delivery of EMS care, results from new initiatives, and payer reimbursement.
- MHCC and MIEMSS should continue to work with payers as they consider the three models of EMS care described in this report.

Recommendations: Public and Private Payers and Hospitals

- Public and private payers should consider implementing creative pilot programs using the three EMS delivery models, including experimenting with payment approaches that have been successfully adopted in other States.
- Hospitals should consider providing additional grants for the three models of EMS care.
- Payers should consider the three models of EMS care when distributing grant funds.

Data and further study

- Current data is barrier to assessment of cost by insurer/insurance type
- Further study is needed
- The Committees, under Insurance Article § 15-1501, could request MHCC to assess the social, medical, and financial impact of mandating private insurers to offer one or more of the new models.

Next Step

- EMS Board approved the report at its January meeting.
- If MHCC approves, the report will be sent to the General Assembly.
- The staff expects that HGO and Senate Finance will request briefings on the report recommendations.

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Legislative Health IT Workgroups Update

(Agenda Item #6)

Health Information Technology Legislative Studies

Status Update

January 17, 2019

MARYLAND The MARYLAND HEALTH CARE COMMISSION

Overview

- Background
- Approach
- About the legislative studies
- Summary and status of the interim reports
- Next steps

Background

- During the 2018 legislative session, staff was tasked with conducting the following health information technology studies:
  - School-Based Telehealth Workgroup (SBT Workgroup)
  - Electronic Prescription Records System Workgroup (EPRS Workgroup)
  - Health Record and Payment Integration Advisory Committee (HRPI Advisory Committee)

Approach

- Broad outreach to ensure diverse stakeholder representation
- Meetings structured in a roundtable-like approach that fosters a collaborative discussion about topics that align with study requirements
- Presentations by workgroup members and industry representatives to share technical knowledge relevant to certain discussion topics
- Information gathering grids that identify benefits, barriers/challenges, and potential solutions are used as the framework to guide workgroup deliberations

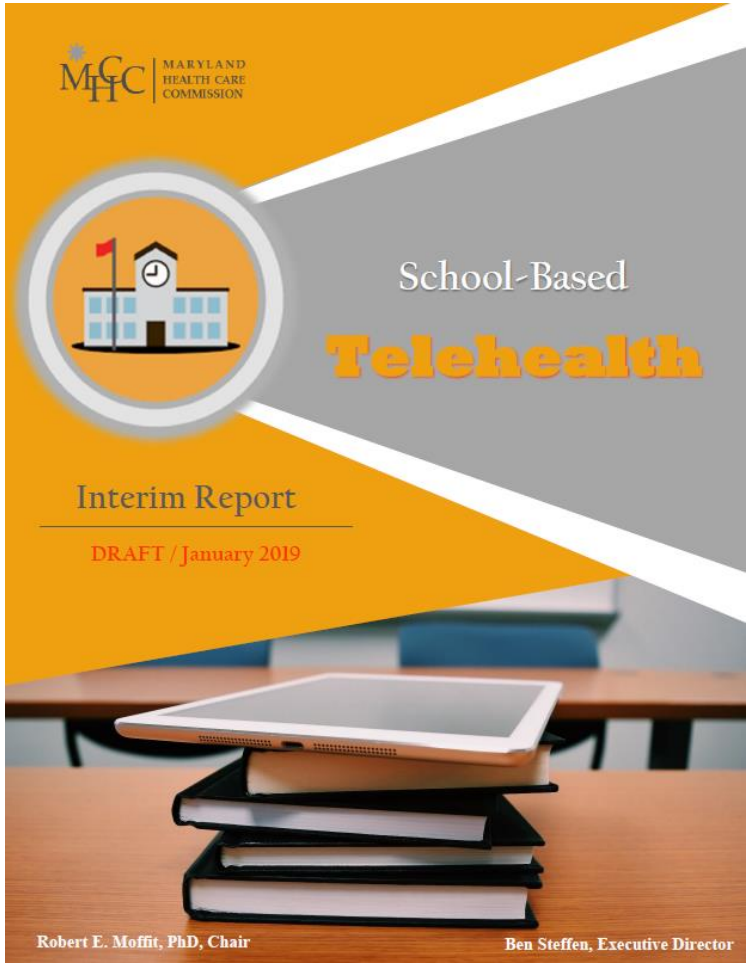
SCHOOL-BASED TELEHEALTH (SBT) WORKGROUP

About the SBT Workgroup

- Requested by Senate Finance Committee
- Charge:
  - Identify deficiencies in current policies related to SBT programs
  - Develop an approach to improve policies
  - Report on findings and recommendations, including legislative and regulatory changes and associated budget estimates, to improve the delivery of SBT services
- Interim presentation during 2019 legislative session; final report due November 2019
- Kick-off meeting May 2018; meetings have occurred about every four weeks

SBT Interim Report

- SBT Workgroup tasks and approach to the work
- Current SBT landscape – Maryland and Nation
- Emerging key themes identified by the SBT Workgroup
- SBT Workgroup objectives in 2019



Key Policy Areas

- Implementation of telehealth within schools
- Building awareness about the value of telehealth
- Ensuring the continuum of care/service coordination via telehealth
- Technology used in telehealth encounters
- Management of people, processes, and procedures to deliver telehealth services
- Existing telehealth compliance requirements
- Establishing adequate funding sources to implement and sustain telehealth programs
- Existing Medicaid and private payor reimbursement models

Emerging Key Themes

Emerging themes that will be deliberated in 2019 include, but are not limited to:

- Establish a flexible telehealth adoption pathway that fosters alternative approaches to using technology where care delivery is equivalent to an in-person office visit
- Engage parents or guardians through outreach and education initiatives that facilitate involvement in the student's health care, and the consent to treat via telehealth can be obtained
- Promote continuity of care in telehealth programs by connecting to local providers or coordinating care with a student's medical home
- Ensure telehealth technology is dependable and meets established State and federal privacy and security laws

Next Steps

- Workgroup deliberations are expected to continue over the next six months
- During the first quarter, the Workgroup plans to finalize key themes that will frame draft recommendations
- Draft recommendations will be vetted with stakeholders in the second quarter
- A presentation of the proposed recommendations is targeted for the September Commission meeting

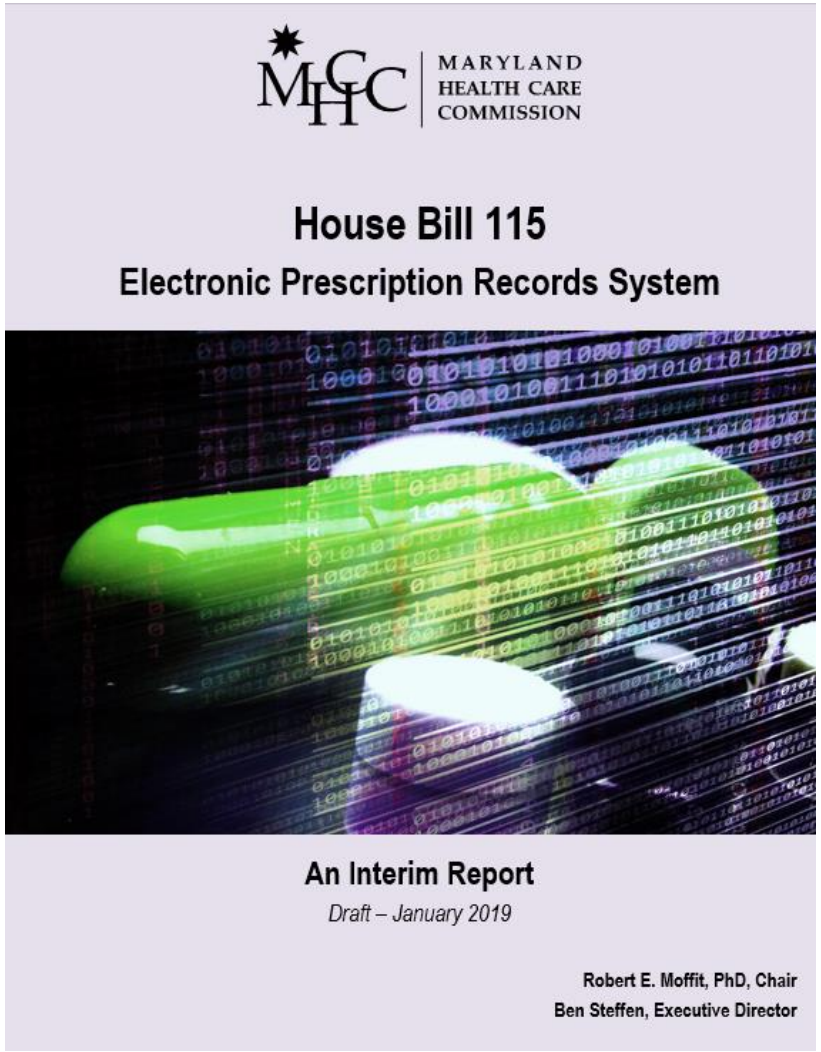
ELECTRONIC PRESCRIPTION RECORDS SYSTEM (EPRS) WORKGROUP

About the EPRS Workgroup

- Required by House Bill 115 (Chapter 435)
- Staff is tasked with convening interested stakeholders to assess the benefits and feasibility of developing an electronic system (or statewide repository) for prescribers and dispensers to access patient medication history for non-controlled dangerous substances (non-CDS)
- Kick-off meeting July 12, 2018; meetings have occurred about every four weeks
- Final report due to the Governor and General Assembly January 2020

Interim Report

- EPRS workgroup overview and approach
- Current landscape
- Emerging key themes
- Next steps in 2019
- Targeted for release in February



Emerging Key Themes

The following key themes have emerged from EPRS workgroup deliberations and will help frame development of proposed recommendations:

- Electronic access to patients' complete medication record can inform clinical decision making and improve patient safety
- A mandate for non-CDS reporting (as opposed to a voluntary approach) for regular reporting by dispensers
- A phased-in implementation strategy that may include pilot projects
- Balance need for patient safety with patient privacy through an opt-out approach
- Consumer education is paramount at the point care delivery if opt-out is permitted

Next Steps

- Workgroup deliberations are expected to continue over the next six months
- During the first quarter, the Workgroup plans to finalize key themes that will frame draft recommendations
- Draft recommendations will be vetted with stakeholders in the second quarter
- A presentation of the proposed recommendations is targeted for the November Commission meeting

HEALTH RECORD AND PAYMENT INTEGRATION (HRPI) ADVISORY COMMITTEE

About the HRPI Advisory Committee

- Required by Senate Bill 896 (Chapter 452)
- Staff is tasked with convening certain stakeholders to assess the feasibility of creating a health record and payment integration program that, among other things, could incorporate administrative health care claim transactions into the State-Designated Health Information Exchange
- Kick-off meeting July 26, 2018; meetings have occurred about every four weeks
- Final report due to the Governor and General Assembly November 2019

Interim Report

- HRPI Advisory Committee overview and approach
- Current landscape
- Emerging key themes
- Next steps in 2019
- Targeted for release in February

Key Themes

The following key themes from HRPI Advisory Committee deliberations have been identified and are guiding development of proposed recommendations:

- Policy, funding, and technical complexities create challenges to support a consolidated infrastructure that support EHRs, health information exchange, and administrative financial services (billing)
- A mandate to connect all 32 electronic health networks to CRISP requires a technical and financial assessment and creates integration challenges that would not be embraced by the industry
- Requirements for the adjudication of clean claims in §15-1005 of the Maryland Insurance Article and COMAR 31.10.11 do not pose challenges to providers at this time

Next Steps

- Advisory Committee deliberations are expected to continue over the next three months
- During the first quarter, the Advisory Committee plans to finalize key themes and draft recommendations
- Draft recommendations will be vetted with stakeholders by the end of the second quarter
- A presentation of the proposed recommendations is targeted for the June Commission meeting

The MARYLAND
HEALTH CARE COMMISSION

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Legislative Process for Calendar Year 2019

(Agenda Item #7)

Maryland Health Care Commission

Legislative Process Overview

A presentation for Commissioners regarding the 2019 Legislative Session

Megan Renfrew, J.D/M.P.A, Government Relations & Special Projects

Version Date: 12/4/2019

MHCC | MARYLAND HEALTH CARE COMMISSION

Presentation Overview

- General Dates of Interest
- 2019 General Assembly Overview
- Key Leaders
- MHCC's Role
- Role of Commissioners
- Bill Review
- Position Paper Development
- Administration Legislation-Governor/Lt. Governor
- Departmental Legislation-MDH
- Privately Sponsored Legislation
- Budget

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General Dates of Interest

- **January 9 -** General Assembly Convenes
- **January 16** -Inauguration of the Governor & Lt. Governor
- **January 18 -** Budget Bill Introduction Deadline
- **January 21 -** Final day for introduction of Administration bills without Senate Rules Committee Referral
- **January 30 -** State of the State Address (noon)
- **February 4 -** Final day for introduction of Senate bills without Senate Rules Committee Referral
- **February 8 -** Final day for introduction of House bills without House Rules & Nominations Committee Referral
- **March 4 -** Final date for introduction of bills without suspension of Rules
- **March 18 –** Opposite Chamber Cross-over Date
- **April 1 -** Budget bill to be passed by both chambers
- **April 8 -** Sine Die

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MHCC Dates of Interest

- **January 17**

- Finance Briefing- Psychiatric Placements (MDH), Telehealth (MHCC- David Sharp), Community Options Waiver (MDH)

- HGO Briefing— Introduction to MDH and the Commissions (HSCRC, MHCC, and CHRC)

- **February 6 –** HGO Briefing- Certificate of Need

- **February 7 -** House Appropriations – Budget Hearing

- **February 11 -** Senate Budget and Taxation - Health & Human Services Subcommittee –Budget Hearing

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2019 General Assembly Overview

Senate

47 Senators
- 32 D; 15 R
- 17 new Senators (9 were Delegates in 2018)

Key Committees (Policy):
- Finance
- Budget and Taxation

House of Delegates

141 Delegates
- 99 D; 42 R
- 43 new Delegates

Key Committees(Budget):
- Health and Government Operations (HGO)
- Appropriations

30 percent turnover

72 women (record number)

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Key Leaders: Senate

Finance

- Chair: Middleton → Kelly
- Vice-Chair: Astle → Feldman
- *Health and Long-Term Care Subcommittee*
  - Chair: Delores G. Kelley

Budget and Taxation

- Chair: Kasemeyer → King
- Vice-Chair: Madaleno→ Ferguson
- *Health and Human Services Subcommittee*
  - Chair: Madaleno > Guzzone
  - Vice Chair: King >TBD

Education, Health, and Environmental Affairs

- Chair: Conway → Pinsky
- Vice-Chair: Pinsky → Nathan-Pulliam
- Health Subcommittee
  - Co-Chairs: Shirley Nathan-Pulliam & Craig J. Zucker

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Key Leaders: House of Delegates

Health and Government Operations (HGO)

- Chair: Shane Pendergrass (no change)
- Vice-Chair: Joseline A. Pena-Melnyk (new role)
- *Health Facilities and Pharmaceuticals Subcommittee*
  - Chair:TBD
- *Health Occupations and Long Term Care Subcommittee*
  - Chair: Ariana B. Kelly
- *Insurance Subcommittee*
  Chair: Bonnie Cullison
- *Public Health and Minority Health Disparities Subcommittee*
  Chair: Joseline A. Pena-Melnyk

Appropriations

- Chair: Maggie McIntosh (no change)
- Vice-Chair: Tawanna Gaines (no change)
- *Public Safety & Administration Subcommittee*
  - Chair: Keith E. Haynes
  - Vice Chair: Mark S. Chang

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MHCC's Role

- Educate legislators on MHCC roles and responsibilities & build relationships for the future
- Suggest legislation (e.g. statutory changes in CON Modernization report)
- Provide support for MHCC budget requests
- Review relevant bills and share MHCC position
- Provide information in MHCC areas of expertise, on request of legislators.

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Role of Commissioners

MHCC Policy Phone Call

- weekly calendar hold, held as needed
- Provide feedback on bills for review; discuss possible MHCC position.

Provide support to MHCC staff on legislative relations, if needed

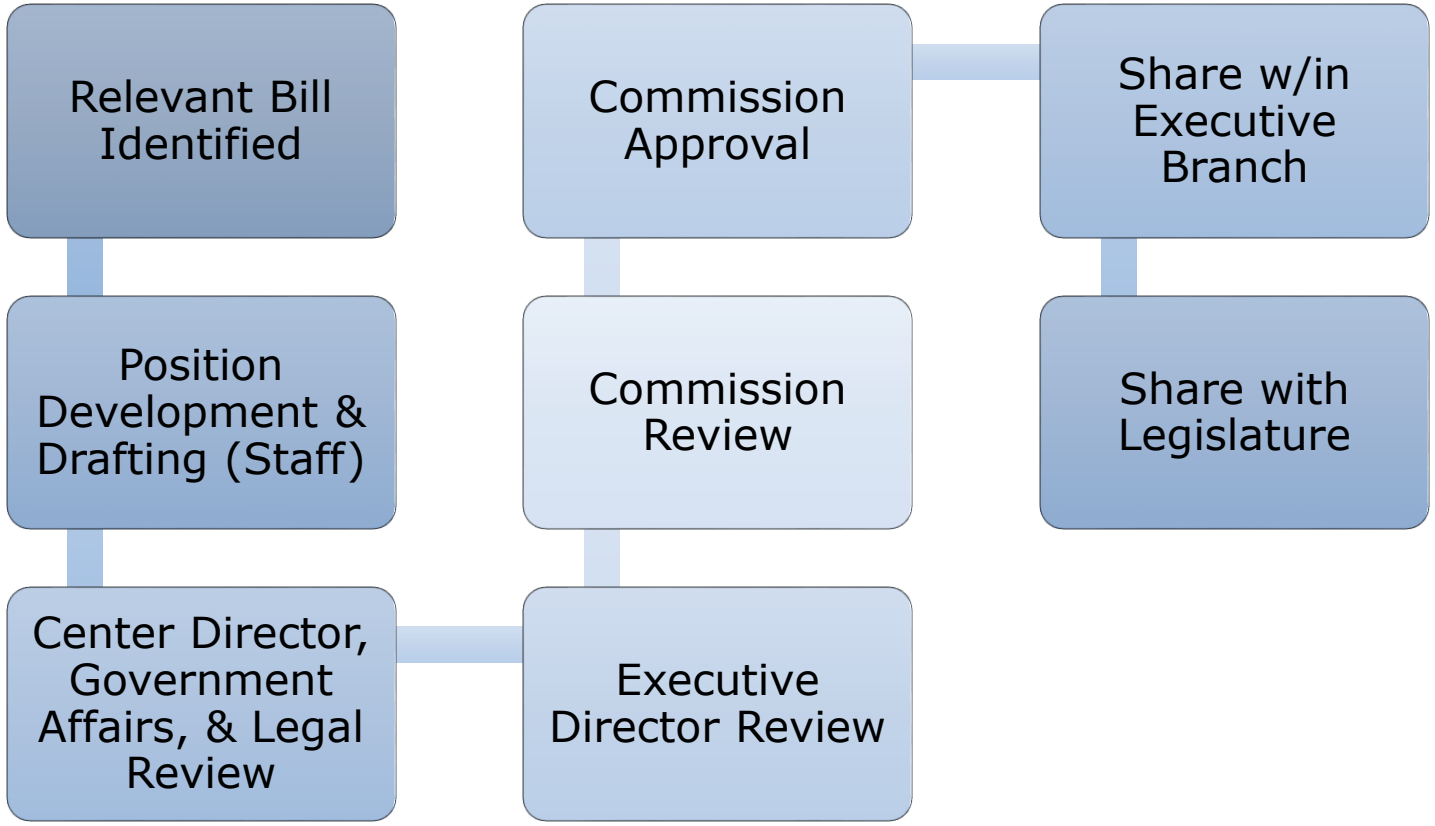
Bill Review

- Topics
  - Related to MHCC stated priorities or statutory responsibility
  - Issue precedent

- Actions
  - Letter of Information/ Letter of Concern
    - Support
    - Support with Amendment
    - Oppose

MARYLAND HEALTH CARE COMMISSION

Position Paper Development



Policy conference calls with Commissioners will be held as needed.

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Administration Legislation

- Administration proposals come from the Governor & Lt. Governor and are the administration's highest priority
- Christopher Shank, serves as Chief Legislative Officer for the Governor's Legislative Office. Mathew Palmer is Deputy Legislative Officer for health topics.
    - *Any amendments to Administration legislation should ONLY be offered by the Governor's Legislative Office, unless otherwise directed.*
    - Concerns about language in Administration legislation or suggestions for amendments should be addressed to the appropriate person on the Governor's staff.

Departmental Legislation

- All executive department bills are approved by the Governor's Legislative Office before introduction; no Executive Branch representative may oppose a departmental bill before the General Assembly.
  - Concerns that arise after introduction should be brought to the attention of the sponsoring agency and, if necessary, the Governor's Legislative Office.
  - Any amendments which a non-sponsoring department feels are necessary should be agreed to and offered by the sponsoring department.
  - Conflicts will be resolved by the Legislative Office of the Governor.

Privately Sponsored Legislation

- Coordinate with the Department on positions
- Legislative liaisons discuss agency positions at weekly Friday meeting
- Generally, conflicts between agencies should be avoided

Budget

- Budget Bill scheduled for introduction on January 18th
- Budget Hearings Scheduled
  - House Appropriations - Public Safety & Admin Subcommittee - February 7
  - Senate Budget and Taxation - Health & Human Services Subcommittee - February 11
- Full Committee
- Chamber Decisions
- Conference Committee
- Must pass by April 1, 2019

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MARYLAND HEALTH CARE COMMISSION

AGENDA

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2. UPDATE OF ACTIVITIES
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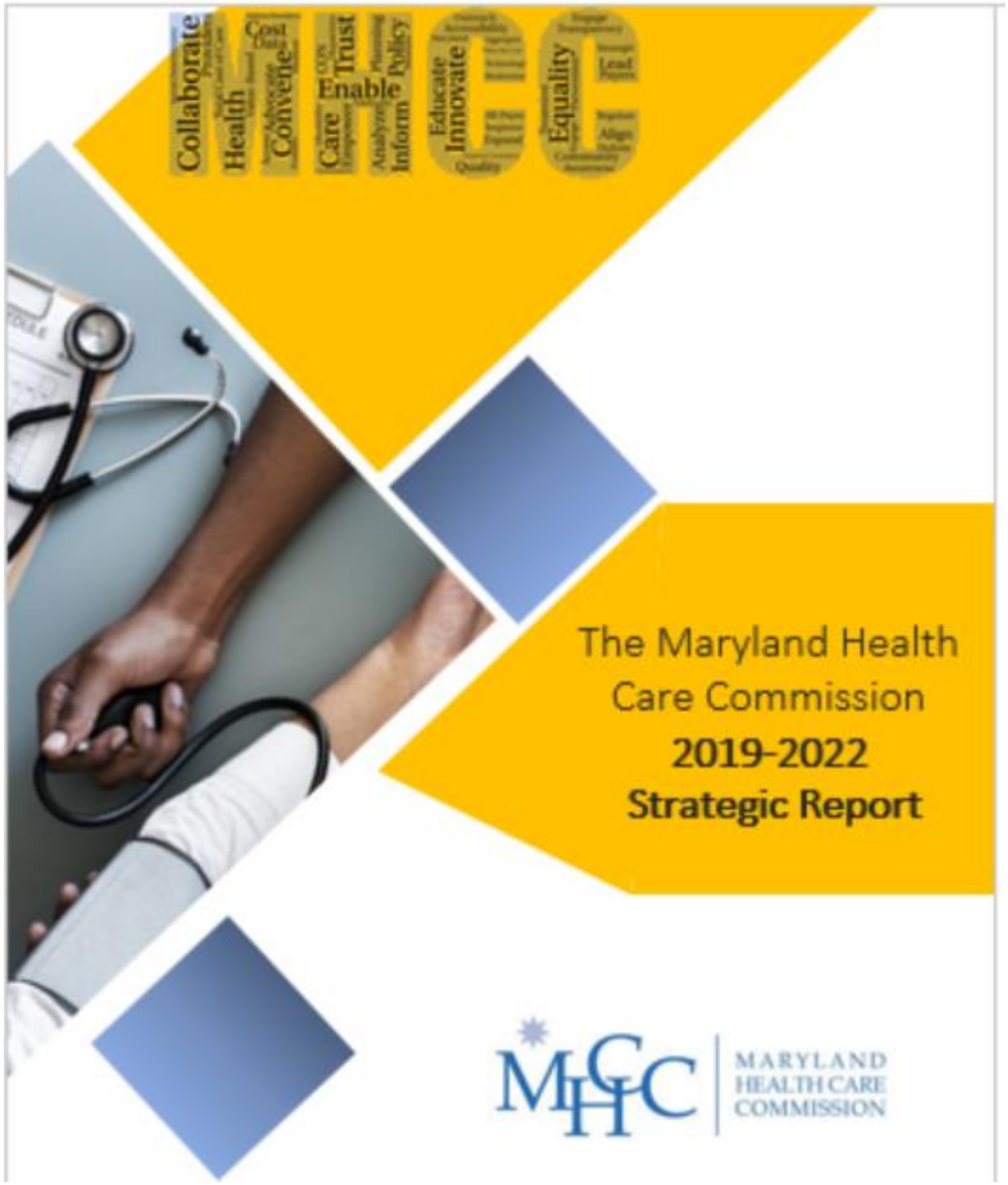
7. PRESENTATION: Legislative Process for Calendar Year 2019
8. **PRESENTATION: MHCC Strategic Priorities**
9. PRESENTATION: State Health Plan Priorities
10. Overview of Upcoming Activities
11. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

MHCC Strategic Priorities

(Agenda Item #8)



Our roles…

- Convene and engage stakeholders
- Measure and aggregate quality data
- Enable information technology innovation
- Assess health policy options
- Plan for health facility development

A Look Back

2015 A Bold Challenge: Maryland Can Perform Better

- Expand Public Reporting of Health System Performance to Drive Transparency
  - ✓ Expanded scope of Maryland Healthcare Quality Reports
  - ✓ Launched WearTheCost
  - ✓ Expanded Data Release
- Elevate Advancement of Primary Care in Maryland
  - ✓ Completed MMPP program
  - ✓ Launched Maryland Practice Transformation Network
  - ✓ Worked with the MDH to implement the MDPCP
- Modernize Health Planning to Address Changing Capacity Needs
  - ✓ Revised State Health Plan to accommodate greater consumer choice
  - ✓ Established framework for hospital conversions to FMFs
  - ✓ Provided greater flexibility for HMOs to provide services
- Promote Use of HIT to Maximize Meaningful Information Sharing
  - ✓ Worked with partners to establish Integrated care network
  - ✓ Supported the integration of advance directives
  - ✓ Developed performance-focused oversight of CRISP

How Maryland compares: More progress is needed

2018 changes in Maryland's health care rankings
Commonwealth Fund State Scorecard

Category	2018 Rank	Change*
Overall	20	-3
Access & Affordability	10	-1
Prevention & Treatment	13	-7
Avoidable Use & Cost	26	+4
Healthy Lives	27	-4
Disparity	31	-10

2018 changes in Maryland's health care rankings
on United Health Foundation State Scorecard

Category	2018 Rank	Change from 2017
Overall	19	-3
Behaviors	10	-3
Community and Environment	25	-3
Policy	11	+6
Clinical Care	17	-0
All Determinants	17	-4
All Outcomes	31	-5

The UH Foundation rankings are not included in the Strategic Priorities report, but provide additional context.

2019-2023 Priorities

- **Educate, inform, and engage the health care community**
  - Develop a strategic communications plan
  - Redesign the MHCC website and improve social media outreach
  - Improve communication to consumers
- **Make MHCC the trusted source of quality and cost information**
  - Expand “Wear The Cost” Price Transparency Site
  - Reducing waste and low-value care by reducing use of unnecessary and low-value as identified by using Choosing Wisely
  - Develop an Outpatient Surgery Comparison tool
- **Modernize health planning and the certificate of need program**
  - Modify CON to complement the objectives of the TCOC Model
  - Provide opportunities for innovators committed to the delivery of affordable, safe, and high-quality care to enter the market
  - Reduce the burden of CON regulatory requirements while maintaining meaningful and fair review criteria and standards

2019-2023 Priorities (continued)

- **Enable providers to participate in value-based payment models**
  - Establish transformation initiatives to prepare practices for participation in value-based payment models
  - Partner with other state agencies to expand initiatives that enable hospitals and other providers
  - Convene practitioner peer learning symposiums on Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) compliance

- **Elevate telehealth**
  - Use peer learning to build provider awareness of telehealth
  - **Identify policies to increase the use of telehealth in value-based care models**
  - Support the implementation of telehealth in a wide variety of health settings
  - Educate providers and patients on the effective use of telehealth

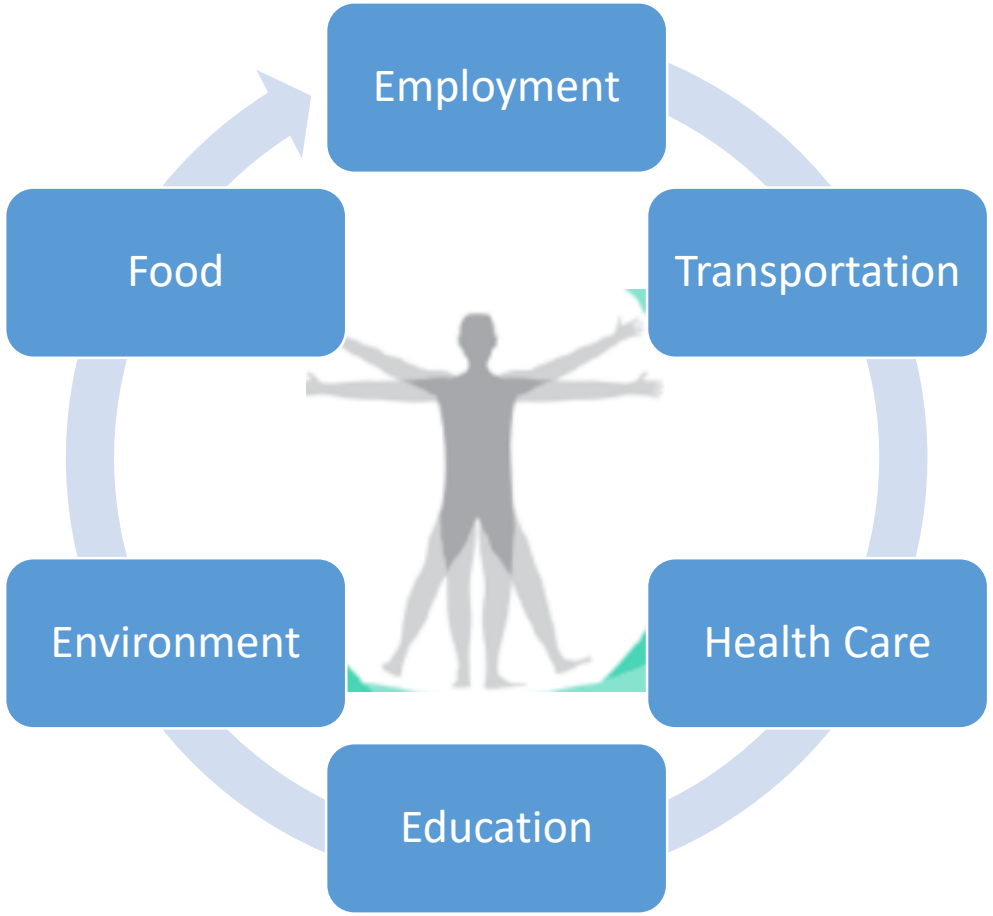
A commitment to work with others to improve social determinants of health

Social determinants are a subset of all determinants of health. Social determinants of health are an underlying cause of today's major health dilemmas including obesity, heart disease, diabetes, addiction, diseases, and depression.

Social determinants include:

- educational opportunities;
- employment opportunities;
- gender inequity and racial discrimination;
- food insecurity;
- access to transportation; and
- access to housing and utility services.

Others determinants include public policy, individual behavioral choices, and biological/genetic risk factors.



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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

State Health Plan Priorities

(Agenda Item #9)

MARYLAND HEALTH CARE COMMISSION

Redevelopment of the State Health Plan Priorities and a Timeline

Maryland Health Care Commission
January 17, 2019

Modernizing CON Regulation – December 2018 Report

- Identify the State Health Plan (SHP) chapters that are most in need of updating and which offer the greatest potential to meet reform objectives and prioritize their revision.

- Primary Guidance on SHP Redevelopment – Limitation of Standards and Simplification

  - Project Need
  - Project Viability
  - Project Impact (on costs and charges and on access to care)
  - Applicant Qualifications

Current State of the State Health Plan

Largely Outdated
COMAR 10.24.07: Psychiatric Hospital Services and Residential Treatment Center Services (1997)
COMAR 10.24.12: Inpatient Obstetrical Services (2002)
COMAR 10.24.14: Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services (2002)

Old But Not Largely Outdated
COMAR 10.24.18: Neonatal Intensive Care Services (1998)
COMAR 10.24.08: Comprehensive Care Facility Services (2007) **(Update currently in process)**

Updated in Last Ten Years
COMAR 10.24.10: General Hospital Services (2009)
COMAR 10.24.09: Rehabilitation Hospital Services (2013)
COMAR 10.24.13: General Hospice Services (2013)

Updated in Last Five Years
COMAR 10.24.16: Home Health Agency Services (2016)
COMAR 10.24.15: Organ Transplant Services (2017)
COMAR 10.24.11: General Surgical Services (2018)
COMAR 10.24.17: Cardiac Surgery and Percutaneous Coronary Intervention Services (2019)

Established in Last Five Years
COMAR 10.24.19: Freestanding Medical Facility Services (2017)

Underdeveloped
COMAR 10.24.08: Chronic Hospital Services (2007)

Frequency of Use

Since 2011, the primary SHP Chapters guiding the review of CON applications for which final decisions (or application withdrawals) have been made are:

	Projects
COMAR 10.24.08: Comprehensive Care Facility Services (2007)*	15
COMAR 10.24.11: General Surgical Services (2018)	13
COMAR 10.24.10: General Hospital Services (2009)	7
COMAR 10.24.13: General Hospice Services (2013)	7
COMAR 10.24.14: Alcoholism and Drug Abuse ICF Treatment Services (2002)	5
COMAR 10.24.16: Home Health Agency Services (2016)	4
COMAR 10.24.07: Psychiatric Hospital Services (1997)	2
COMAR 10.24.07: Residential Treatment Center Services (1997)	2
COMAR 10.24.09: Rehabilitation Hospital Services (2013)	1
COMAR 10.24.17: Cardiac Surgery and PCI Services (2019)	1

*Proposed regulations adopted October 2018

In the Pipeline – January 2019

COMAR 10.24.14: Alcoholism and Drug Abuse ICF Treatment Services (2002)	Projects 4
COMAR 10.24.09: Rehabilitation Hospital Services (2013)	3
COMAR 10.24.15: Organ Transplantation Surgery (2017)	3
COMAR 10.24.07: Psychiatric Hospital Services (1997)	2
COMAR 10.24.13: General Hospice Services (2013)	2
COMAR 10.24.07: Residential Treatment Center Services (1997)	1
COMAR 10.24.08: Comprehensive Care Facility Services (2007)	1
COMAR 10.24.10: General Hospital Services (2009)	1
COMAR 10.24.11: General Surgical Services (2018)	1
COMAR 10.24.16: Home Health Agency Services (2016)	1

Recommended Priorities for SHP Redevelopment – High Priority

1. COMAR 10.24.08: Comprehensive Care Facility Services (2007)

- Bed need forecasting methodology is outdated - balance of plan is 12 years old (but only moderately outdated)
- High frequency use
- Important to improve alignment with Total Cost of Care (TCOC) payment model experiment

2. COMAR 10.24.07: Psychiatric Hospital Services and Residential Treatment Center Services (1997)

- Oldest SHP regulations and largely outdated
- Relatively low frequency use
- A facility category (psychiatric hospital services) perceived to be problematic
  - Emergency department bottleneck
  - Questions with respect to availability and accessibility of bed capacity

3. COMAR 10.24.10: General Hospital Services (2009)

- Ten years old – moderately outdated
- Medium frequency use
- Important to improve alignment with TCOC payment model experiment

Recommended Priorities for SHP Redevelopment - High Priority

4. COMAR 10.24.14: Alcoholism and Drug Abuse ICF Services (1997)

- Most of plan is outdated
- Medium frequency use
- A facility identified in the CON Modernization Report as a poor fit for the CON regulatory model

5. COMAR 10.24.13: General Hospice Services (2013)

- Only six years old but in need of significant streamlining based on recent experience
- Medium frequency use
- Highest level of market concentration among regulated facilities and services – half of jurisdictions have a single general hospice provider
- A facility identified in the CON Modernization Report as a poor fit for the CON regulatory model

6. COMAR 10.24.16: Home Health Agency Services (2016)

- Only three years old but in need of significant streamlining based on recent experience
- Low frequency use
- Important to improve alignment with TCOC payment model experiment
- A facility identified in the CON Modernization Report as a poor fit for the CON regulatory model

Recommended Priorities for SHP Redevelopment – Medium Priority

1. COMAR 10.24.09: Rehabilitation Hospital Services (2013)

- Six years old
- Low frequency use

2. COMAR 10.24.18: Neonatal Intensive Care Services (1998)

- Old but not largely outdated – Perinatal systems standards need to be replaced – already recently updated by MDH
- Very low frequency use

3. COMAR 10.24.11: General Surgical Services (2018)

- Only one year old
- High frequency use
- Will become a higher priority if MHCC recommendations for statutory changes in scope of CON regulation are adopted

Recommended Priorities for SHP Redevelopment – Low Priority

COMAR 10.24.12: Obstetric Services (2002)

- Very old and moderately outdated
- Very low frequency use – only used in review of one project since establishment in 2002

COMAR 10.24.15: Organ Transplant Services (2017)

COMAR 10.24.17: Cardiac Surgery and PCI Services (2019)

COMAR 10.24.19: Freestanding Medical Facility Services (2017)

- These three chapters are fairly new and are likely to be relatively infrequently used over the next few years.

Future COMAR 10.24.08: Chronic Hospital Services (CCF regulations slated to become COMAR 10.24.20 after update anticipated in 2019)

- These regulations will be a "rump" section of the current COMAR 10.24.08
- Very low frequency use – policy direction likely to be largely negative with respect to any new development

Recommended Timeline for SHP Redevelopment*

Targeted Completion of Update in FY 2019

- COMAR 10.24.20: Comprehensive Care Facility Services

Targeted Completion of Update in FY 2020

- COMAR 10.24.07: Psychiatric Hospital Services and Residential Treatment Center Services
- COMAR 10.24.10: General Hospital Services
- COMAR 10.24.14: Alcoholism and Drug Abuse ICF Services
- COMAR 10.24.18: Neonatal Intensive Care Services

Targeted Completion of Update in FY 2021

- COMAR 10.24.11: General Surgical Services
- COMAR 10.24.13: General Hospice Services
- COMAR 10.24.16: Home Health Agency Services

*subject to reconsideration based on any statutory reforms implemented

Update of Procedural Regulations – COMAR 10.24.01

Modernizing CON Regulation – December 2018 Report

1. Create an abbreviated review process for certain uncontested projects.

2. Revise performance requirements for approved projects that include a deadline for obligating the capital expenditure and initiating construction but without project completion deadlines.

3. Establish a process for staff review of certain post-approval project changes
   - Changes in physical plant design,
   - Capital cost increases that exceed defined limits, or
   - Operating cost increases that exceed defined limits.

Other

4. Update to account for statutory changes (cardiac surgery and PCI oversight, freestanding medical facilities, and other smaller changes)

Recommended Timeline for Update of Procedural Regulations

- Target Completion in FY 2020
- Release draft of updated regulations for informal review and comment by July 1, 2019 - developed by MHCC staff with review and advice of a Commissioner consultative group
- Informal review and comment in August-September 2019
- Scheduled meetings with stakeholder groups in Fall 2019 for discussion of comments and possible changes
- Adoption of proposed regulations by MHCC in January 2020
- Adoption of final regulations by MHCC in May 2020

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MARYLAND HEALTH CARE COMMISSION

Overview of Upcoming Initiatives

(Agenda Item #10)


ENJOY THE REST OF
YOUR DAY